Crisis of Conscience in Post-\textit{Roe} America

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I. INTRODUCTION

Less than a month after the Supreme Court overruled \textit{Roe v. Wade}, Dr. Valerie Williams saw a patient in the emergency department; her water had broken at sixteen weeks, making continuing the pregnancy to viability an impossibility. Nonetheless, the hospital’s lawyer told Dr. Williams not to intervene: Louisiana’s near-total abortion ban had just gone into effect.

* © 2024 Elizabeth Sepper. Professor of Law, University of Texas School of Law. These comments were presented as a keynote lecture at the UC San Diego Institute for Practical Ethics and University of San Diego School of Law’s Center for Health Law Policy and Bioethics Conference on The Role of Conscience in the Practice of Medicine and the Rule of Law.
For Dr. Williams, “Going back into that hospital room and telling the patient that she would have to be induced and push out the fetus was one of the hardest conversations I’ve ever had.” The patient screamed for hours from the trauma of pregnancy loss. She began hemorrhaging and “lost close to a liter of blood” before Dr. Williams could staunch the bleeding.

More than a decade earlier, a physician at a Catholic hospital recounted a near identical story of a patient suffering a miscarriage at nineteen weeks pregnant. There, hospital administrators had prevented a D&C based on Catholic religious restrictions, rather than state law. As the patient was “dying before our eyes,” “Dr. S” defied the policy and performed the abortion. Horrified by the permanent injuries inflicted on his patient, he quit, saying “I just can’t do this. . . . This is not worth it to me.”

So-called conscience legislation, I then argued, had created this conflict between the individual provider’s conscience and the institution’s policy and had produced an unjustifiable asymmetry in the treatment of conscience in medicine. Doctors and nurses who would not participate in abortion and tubal ligation could refuse without consequence. Employers had to accommodate them. States couldn’t punish them.

By contrast, doctors and nurses committed to delivering care as a matter of conscience were without legal protection. They could be fired by employers with refusal policies. In many states, providers committed to abortion care had to comply with biased informed consent scripts, subject their patients to waiting periods that increased cost and risk, and perform unnecessary and intrusive ultrasounds. If they breached those legal bounds, they could face criminal charges and disciplinary proceedings. And this was so even though these willing doctors and nurses had equal claims to exercise their consciences.


2. Id.


4. Id. at 1777. Dr. S’s story formed the inspiration for and began the introduction of my first article on conscientious provision of medical care. Elizabeth Sepper, Taking Conscience Seriously, 98 VA. L. REV. 1501, 1502 (2012) [hereinafter Taking Conscience Seriously]. For early writing on this issue in bioethics, see Lisa H. Harris, Recognizing Conscience in Abortion Provision, 367 NEW ENG. J. OF MED. 981 (2012); MARK R. WICCLAIR, CONSCIENTIOUS OBJECTION IN HEALTH CARE: AN ETHICAL ANALYSIS ch. 6 (2011).

5. Sepper, Taking Conscience Seriously, supra note 4, at 1502.
One might think that the issue of conscience in medicine is largely moot with the fall of Roe v. Wade. After all, it was the abortion right that prompted legislation to safeguard conscientious objectors. Now that abortion is banned in many conservative states, the issue might fade away.

One would be mistaken. With the demise of Roe, the asymmetry in the law’s treatment of the consciences of willing and refusing providers will deepen, and conflicts multiply. In states with abortion bans, a large share of providers will effectively find themselves subject to the sorts of restrictions that Catholic and other refusing hospitals earlier imposed. Crises of conscience will develop beyond ob-gyn and emergency medicine in oncology, intensive care, dermatology, and so on. But unlike the response to Roe, the consciences of these providers will elicit little concern from state legislatures.

Refusal laws, however, are expanding. Following the playbook successfully used for abortion, right-wing politicians are poised to authorize refusal of a wider range of services, likely to mean contraception, LGBTQ-affirming treatment, HIV prevention and treatment, and vaccination. These statutes will set up further collisions between the consciences of willing providers and the policies of refusing institutions.

In the near term, blue states will not diverge as dramatically from red states as we imagine, due in no small part to laws authorizing refusal of abortion and other reproductive healthcare. Many states with relatively liberal abortion laws have allowed their healthcare markets to become dominated by refusing healthcare systems. Nationwide, hospitals with Catholic affiliation are 15.8% of the market but are more dominant (in the range of 30% and 40%) in many states—including Colorado, Oregon, Washington, and Wisconsin. Increasingly, physicians in group and private practice are employed by health systems that require them to abide by religious restrictions. While these states have some legal and policy tools available to improve access to comprehensive reproductive care, they will find any number of obstacles in their way.

8. See infra notes 111–13 and accompanying text.
This essay proceeds in four parts. Summarizing my previous writing, Part II explains that since Roe, the law has systematically favored refusing individuals and institutions. This asymmetry was unjustified, because “[c]onscience equally may compel a doctor or nurse to deliver a controversial treatment to a patient in need.”\textsuperscript{10} After Dobbs v. Jackson Women’s Health Organization,\textsuperscript{11} the asymmetry may deepen. In restrictive states, Part III contends, the crisis of conscience for willing providers will increase, even as rights to refusal expand. Part IV identifies several possible complications for the legal framework governing conscience in medicine. It suggests that as refusal bills broaden, they may (unintentionally) shield providers committed to delivering at least some care. And as abortion bans grow more severe, hospitals once categorized as refusing may find themselves willing to perform life- and health-saving abortions. They may experience irreconcilable tension between abortion bans and their (religious and moral) healthcare mission. Part V turns to issues of conscience in those states seeking to safeguard abortion. It argues that the normalization of refusal and the reach of religious healthcare systems will erect major barriers to the expansion of reproductive healthcare in these states. State policies expanding abortion access will have to be carefully designed around shifting constitutional doctrine related to the religion and speech rights of healthcare institutions.

II. MEDICAL CONSCIENCE FROM ROE TO DOBBS

Since Roe, legislation protecting conscience in medicine has treated refusal and provision of care in an asymmetrical way. Refusing individuals and institutions receive protection; willing individuals and institutions do not. And, yet, as I have long argued, conscience equally can motivate provision.

\textit{A. Asymmetrical Legal Treatment}

Within months of the Roe decision, Congress passed the Church Amendment, which exempted hospitals and providers from any duty to perform or participate in abortions or sterilizations. Across the country,
legislatures followed with state corollaries. The primary goal of this lawmaking was to shield Catholic (and other) healthcare institutions from legal obligation and to permit them to deny requests from their medical staff to provide care. These laws tended to permit moral, religious, or conscience reasons for refusal or to allow refusal for any reason at all. They usually failed to differentiate between religious and secular, public and private, and for-profit and not-for-profit institutions.

Since that time, refusal laws have widened in terms of the entities they exempt—from hospitals to insurance companies—and the services they cover—from abortion to family planning and fetal stem cell derived therapies. A handful encompass referral and even information about care. A few states authorize refusal of all kinds of medical care.

The very existence of refusal laws was premised on the view that generally applicable laws and ethical rules created a dilemma for the refuser. The legislation thus gave some license to violate the law, effectively abrogating common law duties to treat a patient consistent with standard of care, ensure informed consent, and provide continuity of care. It then immunized institutions and providers from civil, criminal, and professional liability related to refusal. States also were prohibited from penalizing refusal or excluding refusing providers from public programs.

Refusal laws also created novel employment law obligations to the benefit of refusing staff. Hospitals, doctors’ offices, and clinics could not discriminate against doctors and nurses who declined to provide certain treatments. And so, objectors could wait for a miscarrying woman to become ill rather than perform a D&C. They could deny a patient a tubal ligation following a c-section. And they could do so while working within a hospital with a preference for, or even a religious commitment to, delivering such procedures.

By contrast, physicians conscientiously committed to care received essentially no protection. A handful of federal and state laws barred discrimination against a provider who performs lawful abortions or sterilizations outside of the hospital walls or who publicly expresses pro-

13. Id. at 6–7.
15. Sepper, Conscientious Refusals, supra note 9.
16. Sepper, Not Only the Doctor’s Dilemma, supra note 9, at 401–03.
17. See, e.g., 42 U.S.C. § 300a-7(c) & (e) (2000).
choice viewpoints. A few statutes could be read to extend further. But in practice, hospitals routinely flouted even these minimal guarantees.

Likewise, under state and federal laws, only when an institution refused to deliver legal, necessary care—as Dr. S’s did—would the law recognize a concept of “institutional conscience.” In these refusing hospitals, staff of all faiths, beliefs, and backgrounds had to fall in line. By contrast, institutions willing to deliver abortions had to accommodate individual objectors. Their interests ceded to the protection of individual providers.

And that binary applied even to a single hospital. In most jurisdictions, the same facility—religious or not—could alternate between refusing and willing. A Baptist hospital would find its interests prioritized when it refused abortions. But it had to accommodate a conservative Catholic nurse unwilling to assist in tubal ligations.

**B. Equal Claims to Conscientious Provision**

If the goal is to safeguard conscience, the law’s asymmetrical treatment of refusal and provision cannot be justified, because conscience can equally motivate provision of care. For some doctors and nurses, the decision to provide abortion, contraception, and sterilization implicates deeply felt moral, ethical, and religious values. And some providers may be compelled by conscience to perform these procedures.

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18. The Church Amendment prohibits discrimination against “any physician or other health care personnel . . . because he performed or assisted in the performance of a lawful sterilization procedure or abortion . . . or because of his religious beliefs or moral convictions respecting sterilization procedures or abortions.” 42 U.S.C. § 300a-7 (2000). Four states shield providers from discrimination based on “willingness” or expression of willingness to perform abortions, something that comes closer to speech than provision. See Nadia N. Sawicki, *The Conscience Defense to Malpractice*, 108 CAL. L. REV. 1255, n.81 (2020) (compiling statutes).

19. See S.D. CODIFIED LAWS § 34-23A-13 (2020) (prohibiting employment discrimination against any “physician, nurse, or other person who performs or refuses to perform or assist in the performance of an abortion”); WASH. REV. CODE § 9.02.150 (2019) (prohibiting employment discrimination “because of the person’s participation or refusal to participate in the termination of a pregnancy”).

To begin with a basic definition, conscience refers to “human knowledge of right and wrong, and thus our moral consciousness, process of moral decision making, and settled moral judgments or decisions.”\(^{21}\) It represents not mechanical application of a rule but rather a process by which a person identifies moral principles, assesses context, and decides whether to pursue action.\(^{22}\) Conscience thus compels action or withholding of action.\(^{23}\) We may disagree over questions of right and wrong, but every person is capable of experiencing conscience in determining the morality of their actions. And while convictions may derive from faith, religion has no monopoly on conscience.\(^{24}\)

Ethicists have long tended toward the view that conscience has real importance because it is closely related to one’s moral integrity or sense of self.\(^{25}\) Many moral traditions agree that failing to follow one’s conscience causes a sort of psychological schism between what one has done and who one really is.\(^{26}\) To the extent that we seek to accommodate conscience, it is not because of the objective truth or falsity of an individual’s commitments but because of the serious harm to integrity from constraining conscience.\(^{27}\)

The practice of medicine gives rise to both conscientious refusal and commitment. To be clear, most refusals of abortion are not conscientious.\(^{21}\)


\(^{22}\) Sepper, *Taking Conscience Seriously*, supra note 4, at 1527.

\(^{23}\) Charles E. Curran, *Conscience in the Light of the Catholic Moral Tradition*, in CONSCIENCE: READINGS IN MORTAL THEOLOGY No. 14, at 3, 3 (Charles E. Curran ed., 2004) (“Conscience is generally understood as the judgment about the morality of an act to be done or omitted and already done or omitted by the person.”).

\(^{24}\) Sepper, *Taking Conscience Seriously*, supra note 4, at 1533.


\(^{26}\) Vatican II, *Dignitatis Humanae* ¶ 3 (1965), available at https://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_decl_19651207_dignitatis-humanae_en.html [https://perma.cc/T7ZS-G56Z] (“He is bound to follow this conscience faithfully in all his activity so that he may come to God, who is his last end. Therefore he must not be forced to act contrary to his conscience.”); MICHAEL G. BAYLOR, *ACTION AND PERSON: CONSCIENCE IN LATE SCHOLASTICISM AND THE YOUNG LUTHER* 254 (1977) (“Luther continued to assert the principle that it is always wrong to act against conscience”); 1 HANNAH ARENDT, *THE LIFE OF THE MIND* 186 (1978) (arguing for the importance of being consistent with oneself).

\(^{27}\) Sepper, *Taking Conscience Seriously*, supra note 4, at 1508 (compiling and summarizing sources).
Around 75 to 85 percent of ob-gyns do not perform abortions,28 often due to the danger, politics, and non-lucrative nature of abortion provision.29 “Conscientious refusals” take place when a provider consults her conscience and determines that she cannot participate in a procedure that the profession has determined is ethically and legally permissible for doctors to perform.30 The exercise of conscience arises in the specific circumstance where a patient, an institution, or the state requests or requires the procedure.

“Conscientious commitment” instead refers to an individual doctor or nurse who for reasons of conscience seeks to participate in delivering a contested but medically sound treatment when a patient requests and needs it.31 A willing provider experiences conflicts when an institution—or a state law—says no, you can’t provide a treatment that your conscience calls you to deliver. Again, like refusal, provision of care may be disconnected from conscience, manifesting preferences, standards of care, economic realities, and so on. That said, the willingness to deliver under threat of sanction and stigma signals sincerity or even conscience.

So what does conscientious commitment look like in practice? A fairly regular pattern occurs in hospital settings. Doctors see a pregnant woman miscarrying with no chance of fetal viability and serious danger to her health and wellbeing. In such circumstance, a willing provider might invoke the sanctity of life and insist that he cannot be forced to make the woman suffer and risk death. More generally, abortion providers describe encountering women whose pregnancies endangered their lives, girls who had suffered rape or incest, and mothers who were too poor to raise another child. From various faith and moral perspectives, they resolve to perform abortions, compelled by patients’ situations and respect for their moral agency.32


29. Weigel et al., supra note 25 (finding that the most commonly cited reasons for not providing abortion are practice having a policy against it (49%), saying that services are readily available elsewhere (45%), personal opposition (31%) and in some regions legal regulations).

30. Sepper, Taking Conscience Seriously, supra note 4, at 1508.

31. Id.

32. Dr. Willie Parker, for example, describes changing his mind about the morality of abortion after listening to Dr. Martin Luther King’s sermon on the Good Samaritan and examining his own conscience and becoming one of three abortion providers in Mississippi. Sepper, supra note 9, at 385–86. For historical accounts of physicians driven by conscientious
Leading bioethical accounts agree that in order to be respected, physicians’ conscientious judgments whether willing or refusing should be plausibly rooted in shared professional norms. As a result, conscience claims traditionally have focused on obligations of doing no harm or preserving life—that is, issues on which there can be good faith disagreement between physicians in their roles as healthcare providers. We’re not talking about purely idiosyncratic or subjective acts of conscience, not the sun god made me do it, not I must deliver Ivermectin. And because ethical codes tend to insist on roots in professional ethics, “claims of conscientious objection, at least until recently, have not been anarchic.”

Now, one common objection insists that this asymmetry is justified by a moral distinction between being compelled to act and being compelled to refrain from action. As this argument goes, legislatures should be most concerned with doctors being forced to perform procedures that violate their deepest commitments. But as Mark Wicclair has argued, “one’s moral integrity can be damaged by either performing an action that is contrary to one’s core ethical beliefs or by failing to perform an action that is required by those beliefs.” And law and religion doctrine in the United States does not treat acts and omissions as distinct.


33. Elizabeth Sepper, Doctoring Discrimination in the Same-Sex Marriage Debates, 89 Ind. L.J. 703, 734–39 (2014) (exploring this principle) [hereinafter Doctoring Discrimination]; Holly Fernandez Lynch, Conflicts of Conscience in Health Care 34 (2008) (limiting objection to “refusals grounded in values that are widely held within the profession”); Carolyn McLeod, Referral in the Wake of Conscientious Objection to Abortion, 23 Hypatia 30, 38 (2008) (“[P]hysicians cannot make conscientious objections in their practices that violate established norms of the profession that are morally justified”).

34. Franklin G. Miller & Howard Brody, Enhancement Technologies and Professional Integrity, Am. J. Bioethics 15, 15 (May–June 2005) (listing “1) the prevention of disease and injury and promotion and maintenance of health; 2) the relief of pain and suffering caused by maladies; 3) the care and cure of those with a malady, and the care of those who cannot be cured; and 4) the avoidance of premature death and the pursuit of a peaceful death”).

35. There is no evidence that anyone has ever conscientiously provided Ivermectin, though providers refuse to do so for reasons of professional ethics, morality, or perhaps conscience.

36. Sepper, Doctoring Discrimination, supra note 33, at 739.

In medicine in particular, a distinction between acts and omissions fails to work for two basic reasons. First, the lines between acting and omitting are not always clear. Consider an ectopic pregnancy, a nonviable pregnancy where an embryo attaches outside the endometrium, usually in the fallopian tube—a condition that can result in hemorrhage and death. Some refusing providers would insist on removal of the fallopian tube, a surgical procedure that jeopardizes future fertility. A willing provider might instead prefer the administration of methotrexate, a less-invasive drug that preserves fertility. Both providers agree on the sanctity of life, and the effects on conscience are the same; both are arguably doing one treatment and omitting another. Second, moral responsibility is a function of the role-specific obligations of healthcare providers to patients. A doctor who unilaterally omits to deliver CPR will be considered to have harmed the patient. Another who fails to inform a patient of a fetal anomaly is morally responsible whether we consider her to actively harm or simply allow harm.

As to so-called “institutional conscience,” suffice it to say that artificial entities—hospitals, doctors’ offices, and clinics—cannot exercise conscience as human beings do. The value of moral integrity does not translate into business organizations. That said, some healthcare institutions may reflect the associational interests of individuals or create a conduit for the pursuit of religious ends—values worth considering and sometimes protecting. But these values are not limited to refusing entities. Institutions committed to delivering care equally may unite people behind a specific moral identity or purpose. And they too may implement rules important to their mission.

Here, one might raise the argument that accommodation of a dissenter is necessarily more burdensome on refusing hospitals than their willing counterparts. But accommodation of conscientious commitment usually consumes few resources. Sterilization following c-section is a classic case where the difference in equipment, staffing, or time is insignificant. Likewise, performing a D&C for miscarriage avoids potential admission

38. Sepper, Taking Conscience Seriously, supra note 4, at 1509.
39. Id. at 1537; see also Alberto Giubilini, Conscientious Objection in Healthcare: Neither a Negative Nor a Positive Right, 31 J. CLINICAL ETHICS 146, 152 (2020) (discussing how for firefighters, police officers, or lifeguards “their obligations to actively do something to rescue people are stronger than in the case of ordinary people. . . . The doing/allowing distinction weighs differently because professional obligations are predominant.”).
40. Sepper, Taking Conscience Seriously, supra note 4, at 1539–47.
41. These interests are not, however, well represented by modern hospitals, which hire and serve a religiously plural population and have as their and their primary and overwhelming mission to deliver healthcare.
to a hospital bed. By contrast, to accommodate refusing individuals, a willing institution has to double-staff, to schedule procedures at limited times, or to deny services altogether.\footnote{43}

Another form of this argument dwells instead on metaphysical burdens. From this point of view, a willing hospital can achieve its goals despite dissenters, but a refusing hospital faces irremediable harm to its identity from, for example, a single sterilization. This argument is based on the flawed premise that a defining characteristic of refusing institutions is their “exclusionary or absolutist” values.\footnote{44} In fact, there is substantial flexibility and variation in refusal policies. Refusing hospitals can distance themselves from individual providers or procedures—and often do so.\footnote{45} While at the margins it may be easier for a willing hospital to accommodate refusal while providing care,\footnote{46} willing institutions equally can be absolutist—“we always treat ectopic pregnancies to preserve fertility” or “the patient determines the course of her pregnancy.”\footnote{47} In overlooking the diversity of moral beliefs, legislation shifted the costs of refusal onto willing providers and willing institutions.

In my early writing, I was inclined to give lawmakers the benefit of the doubt. Protecting conscience has value and legislators claimed its importance. The asymmetrical treatment of conscience, however, was a warning sign. Today, it is clear to me that conscience legislation served as a placeholder for anti-abortion policy goals. It worked to limit access and to de-legitimize standard-of-care medical practice. The asymmetrical legislative framework also obscured the once commonplace understanding that conscience can compel abortion and other reproductive care.\footnote{48}

\footnote{43} Giubilini, supra note 39, at 150.\footnote{44} Dominic J.C. Wilkinson, Positive or Negative? Consistency and Inconsistency in Claims of Conscience, 31 J. of CLINICAL ETHICS 143, 144 (2020).\footnote{45} Workarounds and separate facilities have been commonplace. E.g., Debra B. Stulberg et al., Tubal Ligation in Catholic Hospitals: A Qualitative Study of ObGyns’ Experiences, 90 CONTRACEPTION 422, 428 (2014) (describing operating room in which clinic staff, not employed by system, were permitted to do tubal ligations).\footnote{46} Sepper, Taking Conscience Seriously, supra note 4, at 1547–53 (explaining why this distinction does not hold as a general principle).\footnote{47} Wilkinson, supra note 44, at 144 (criticizing Brummet).\footnote{48} Dubow, supra note 12, at 18 (arguing that the 1973 arguments over conscientious commitment were “obscured by the Church Amendment’s implication that only those whose consciences opposed abortion required legislative protection”).
III. CONSCIENCE IN RED

With the Supreme Court’s overruling of Roe, the asymmetry between conscientious objection and conscientious provision is likely to become still more pronounced. Rather than extend safeguards to conscientious providers as Professor Fox contends, states with abortion bans likely will look more hostile to conscientious provision and still more welcoming of refusal, whether conscientious or not.

A. Absence of Accommodation of Willing Providers

To state the obvious, abortion bans coerce conscientious providers. Where abortion is criminalized, physicians now experience the sorts of policies, scrutiny, and surveillance that were once limited to their colleagues in refusing hospitals. Practitioners in a variety of specialties feel the constraint on their exercise of medical—and sometimes moral—judgments.

As states criminalize standard-of-care treatment whether for abortion, assisted reproductive technology, or gender-affirming care, one might think that the conflict reduces to state versus provider. But institutions remain central to creating and resolving crises of conscience. Under near-total abortion bans, hospitals will be the sites where most legal abortions take place (or are barred). Indeed, some state laws explicitly limit the performance of excepted abortions to hospitals.

Much controversy at the institutional level will revolve around state law exceptions to abortion bans and the federal Emergency Medical Treatment and Labor Act (EMTALA). Even after Dobbs, where a pregnant person has an emergency medical condition—ranging from early preeclampsia to ectopic pregnancy—hospital emergency departments and their staff have legal obligations to stabilize their condition. EMTALA’s definition of emergency, though narrow, encompasses a larger range of situations than do the exceptions for life-saving care under many abortion bans.

51. E.g., IND. CODE § 16-34-2-1(a).
53. Compare EMTALA, 42 U.S.C. § 1395dd(e)(1)(A) (2020) (“[T]he absence of immediate medical attention could reasonably be expected to result in placing the health of the individual . . . in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part”) with Texas’s abortion trigger ban, Tex. HEALTH & SAFETY CODE ANN. § 170A.002 (West 2022) (“[A] life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that places the female at
As the Department of Health and Human Services reminded healthcare entities in 2021 and 2022, abortion may be required stabilizing treatment under EMTALA.

Within a few months of Dobbs, reports from physicians indicated that many hospitals were taking defensive interpretations of state abortion bans and narrow readings of EMTALA—in effect, restraining doctors from acting in scenarios where exceptions should apply or where EMTALA requires intervention. Missouri hospital chains, for example, briefly withheld emergency contraception.54 Major pharmacy chains would not dispense methotrexate without information usually not demanded of patients or doctors.55 Providers were instructed to stay silent about options or referrals for pregnancy complications.56

Across the board, hospitals will likely play a key role in surveillance, control, and reporting.57 The degree of their control over medical practice distinguishes the time of Dobbs from the pre-Roe era. Fifty years ago, quiet lawbreaking was more plausible. Most physicians were in small or solo practices. Admitting privileges were essentially open, giving institutions limited leverage over physicians. Physicians operated with a high level of independence and little oversight within hospitals. Today, most doctors are employed by healthcare systems or work within larger group practices. Admitting privileges are restricted to physicians who admit significant numbers of patients to hospitals.

Ironically, providers in refusing hospitals also increasingly find themselves in situations that challenge their consciences. Willing hospitals previously offered a release valve. Where an ethics committee or institutional actor refused to permit ectopic pregnancy treatment, miscarriage management, risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed or induced”).

57. See generally Ji Seon Song, Policing the Emergency Room, 134 HARV. L. REV. 2646 (2021) (analyzing how policing in the emergency room is bolstered by medical professionals’ participation); MICHLE GOODWIN, POLICING THE WOMB 78–97 (2020) (documenting ways in which medical staff initiate, investigate, and enforce fetal protection statutes against pregnant women).
or emergency D&C, a physician could transfer the patient (at least in theory).58 Now, the closest hospitals able to legally perform such procedures can be hundreds of miles distant. Refusing institutions, moreover, will restrict abortion beyond the bounds of state bans. As Nadia Sawicki aptly observes, “[i]f a state prohibits all abortions except in the case of rape or incest, a doctor or hospital who refuses to perform an abortion in such cases will be protected”59—generating additional conflicts with medical staff.

The treatment of physicians in refusing hospitals serves as a cautionary tale. Reports indicate that nurses routinely police doctors; other staff file complaints with ethics committees about procedures suspected to violate religious rules; and ethics committees erect hurdles above the requirements of law.60 Concerned about violating policies, individual providers themselves come to gatekeep access. They hesitate to provide care that rules do not explicitly prohibit and bring to ethics committees for approval only cases that very clearly fall within policy exceptions.61

Now, however, these healthcare providers stand to face not only social pressure and adverse employment action but also draconian criminal penalties.62 Before Dobbs, some argued that providers could work elsewhere and patients seek care in another facility. This critique was always unconvincing. From a patient perspective, urgent and emergent situations disallowed shopping, and managed care further limited possibilities.63

58. Emily Stewart, Many Hospitals Refuse to Provide Reproductive Care, Even In States Where Abortion Remains Legal, HEALTH AFF. (Nov. 16, 2022), https://www.healthaffairs.org/content/forefront/many-hospitals-refuse-provide-reproductive-care-even-states-abortion-remains-legal (recounting that hospital newly joined to Catholic system prevented aid to a pregnant woman in the middle of a miscarriage of twins and doctor thus sent the patient on a 90-minute ambulance ride to another hospital); LORI FREEDMAN, WILLING AND UNABLE: DOCTORS’ CONSTRAINTS IN ABORTION CARE 128 (2010) (describing several such cases); Elizabeth Reiner Platt, Katherine Franke, Candace Bond-Theriault & Lilia Hadjiivanova, THE LAW, RIGHTS, AND RELIGION PROJECT, THE SOUTHERN HOSPITALS REPORT: FAITH, CULTURE, AND ABORTION BANS IN THE U.S. SOUTH 15 (2021) (describing transfers under policies of Protestant and sometimes secular refusing hospitals).


60. E.g., Wong et al., infra note 63, at 65 (reporting “one maternal fetal medicine physician noting that if they were caught counseling or providing contraception, “the nurse would turn you in.”); Platt et al, supra note 47, at 28–30 (describing abortion committees in secular and Protestant hospitals in the South).

61. Platt et al, supra note 58, at 35.


63. Id. at 1558; see also Zarina J. Wong et al., What You Don’t Know Can Hurt You: Patient and Provider Perspectives on Postpartum Contraceptive Care in Illinois
For employees, the consolidation of hospital markets meant few options for employment or care. The argument also cut both ways—a refusing provider equally could be told to work in a setting reflective of his beliefs. But in restrictive states, this argument has been rendered obsolete, amounting to a requirement to flee the state for work or medical care.

In sum, for willing providers, the experience and compulsion of conscience remains the same, what has changed are the consequences. But those consequences will not be lifted as they have been for refusing providers. Setting aside practical and principled obstacles to accommodating willing providers, the political reality is that no anti-abortion legislature will attempt to resolve the crises of medical conscience that near-total abortion bans create. Consider that in passing an SB8-style abortion ban, Oklahoma specifically exempted the bill from its religious freedom restoration act. These acts typically allow religious objectors to argue that state laws burden their free exercise in ways the state cannot justify. The state anticipated and sought to guard against religious exemptions related to abortions. Deference to religious conviction evaporated.

B. Refusal Run Wild

Even as conscientious commitment stands to go unprotected, recent years have seen rising interest in expanding the reach of refusal laws. A raft of new refusal bills is being proposed, and versions have passed in Ohio, Arkansas, South Carolina, Florida, and Montana. Their language...
is sweeping. They extend to all healthcare services including diagnosis, prognosis, and referral and to administrative activities like recordkeeping. They authorize an extensive group of individuals and institutions to deny care. There is no duty to refer or inform patients.

Jehovah’s Witnesses could refuse to transfuse patients. A vegan could withhold vaccines that contain egg proteins on the ground that the use of animal products is morally wrong. More likely, psychologists will turn away patients in same-sex relationships. Administrative staff will fail to schedule STI testing. Clinics will object to fostering immoral sexual activity by prescribing PrEP to prevent HIV. Doctors won’t refer pregnant patients for prenatal genetic testing. None could be held “civilly, criminally, or administratively liable” for declining to participate in these services for reasons of conscience.

The invitation to deny standard-of-care medicine makes patients more vulnerable. Because modern healthcare relies on a team, objecting support staff—whether receptionists, physician assistants, or radiologists—can deny and delay patient treatment and generate friction between medical providers. And these anti-standard-of-care bills create heightened risk because it is increasingly important to avoid unintended pregnancy and to obtain evidence-based reproductive care. Without access to abortion, refusal of tubal ligation, emergency contraception, IUDs, and oral contraception more significantly harms patients.

This newest iteration of refusal bills also creates absolute duties to accommodate refusing employees. Previously, an employer usually had to reasonably accommodate a refusing employee. It could take into account

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68. ARK. CODE ANN. § 17-80-503(5) (West 2022). Throughout this essay, I use the language of Arkansas law, which closely tracks the bills proposed in other states.


70. Joel Frader & Charles L. Bosk, *The Personal Is Political, the Professional Is Not: Conscientious Objection to Obtaining/Providing/Acting on Genetic Information*, 151C AM. J. MED. GENETICS 62, 63 (2009) (noting objectors who “not only refuse to inform patients about available prenatal genetic testing but also refuse to refer”).

71. ARK. CODE ANN. § 17-80-504 (West 2022).
burdens on other employees, administrators, and, importantly, patients. Some state laws already appeared to require something much more burdensome from employers. But these latest bills are explicit in moving from a duty of reasonable accommodation to a duty of absolute accommodation. No longer do burdens on other healthcare providers or on patients necessarily justify rejecting accommodation of a refusing staff member.

What is truly novel about these bills is that religious institutions have it both ways. The bills exempt any entity that holds itself out as religious, has a religious purpose in governing documents, and promulgates religion-based policies—a group that would include many religiously affiliated healthcare institutions and probably a number of for-profit organizations. These institutions could refuse any healthcare service. They also would bear no duty to accommodate or retain individual staff with contrary beliefs (or commitments to refuse other services). The statutory language grants religious institutions “the right to make employment, staffing, contracting, and admitting privilege decisions consistent with his, her, or its religious beliefs.”

As a result, a Catholic hospital would receive carte blanche to restrict healthcare whenever it conflicts with Catholic doctrine—a much bigger pool of healthcare services than abortion and sterilization, including contraception, the least invasive treatments for ectopic pregnancies, treatments derived from embryonic stem cells, and assisted reproductive technologies. It could, without liability, enforce its religious mandate


74. Ark. Code Ann. § 17-80-504(c) (West 2022). But as a matter of state employment law, the bills go much further. Although it’s beyond the scope of this paper, authorizing decisions “consistent with religious beliefs” opens the door to discrimination against employees based on sexual orientation, pregnancy, marital status, disability, and beyond. In this sense, it creates a statutory version of the “ministerial exception” under constitutional religion clause doctrine, which frees churches and affiliated schools from compliance with all civil rights laws but then makes the carveout available to a wide universe of entities that would not qualify for the ministerial exception.

that patients only be informed of “morally legitimate alternatives.”\textsuperscript{76} It could also refuse to provide gender-affirming care for transgender patients, a position Catholic hospitals often take. And they could enforce these rules with no obligation under state law to accommodate or retain employees who disagree for reasons of conscience.

This statutory provision responds to what I called the “trump card for the most refusing refuser” under state conscience laws.\textsuperscript{77} No longer would the Baptist hospital have to accommodate the conservative Catholic physician who refuses contraception. The religious institution would prevail regardless of whether it is in the posture of willing or refusing provider. Identically situated secular institutions, however, would continue to bear obligations to staff around refusing individuals.

For now, federal statutes provide a limited backstop to these anti-standard-of-care bills. Healthcare providers must comply with laws that prohibit discrimination—as is most relevant here—on the basis of sex, sexual orientation, and gender identity in both employment and healthcare delivery. Emergency departments also retain their duties under the Emergency Medical Treatment and Labor Act. But it is only when a patient’s condition rises to the level of an emergency medical condition that EMTALA would preempt the healthcare provider’s right to deny care, information, advice, and so on under state law.

But beyond these constraints, legislatures seem bent on following the anti-abortion playbook to foster refusal of care and to promulgate a one-sided vision of conscience. Abortion refusal laws were an important part of an overarching political economic strategy that insulated hospitals from abortion politics and practice. The result was to isolate abortion clinics, making them easy targets for anti-abortion activists and politicians. The same may become true for gender-affirming care, family planning services, and vaccination. Like its predecessors, this generation of refusal laws may ossify and spread misunderstanding of medical science (as has occurred with emergency contraception, often confused with medication abortion).\textsuperscript{78} It similarly may have the effect of cloaking all denial of care in the mantle of moral, religious, or conscientious values.

In sum, abortion bans stand to substantially infringe on medical conscience. Yet, I predict, legislatures will be unmoved by the increasing

\textsuperscript{76} Id. at 14.
\textsuperscript{77} Sepper, Taking Conscience Seriously, supra note 4, at 1550.
\textsuperscript{78} Laura E.T. Swan et al., Physician Beliefs about Contraceptive Methods as Abortifacients, AM. COLLEGE OF OBSTETRICS & GYNECOLOGY (2022), https://www.ajog.org/action/showPdf?pii=S0002-9378%2822%2900772-4 [https://perma.cc/X8E3-SMWY] ("Approximately 1 of 6 obstetrician-gynecologists, and even more among other specialties, held misconceptions about IUDs and EC as abortifacients.").
moral distress of doctors, nurses, and other healthcare providers under abortion bans. And as refusals proliferate to new services, contexts, and staff, the crisis of conscience will worsen.

IV. CONSCIENCE COMPLICATIONS

This Part briefly and tentatively suggests two complications for the expanding conscience framework in anti-abortion states. First, as refusal regimes grow, some measure of conscientious provision may be shielded. The statutory text of the newest generation of bills invites some degree of provision contrary to institutional policy and state law. Second, as exceptions from abortion bans narrow, institutional categories may become so unstable as to bring the regime to the point of collapse. Hospitals traditionally protected as refusing institutions may find they are willing to deliver some categories of emergency (or other) abortions that state laws no longer allow. Willing institutions traditionally excluded from protection may gain rights under expansive new refusal laws to implement pro-reproductive-care norms and to hire their staff accordingly.

A. Conscientious Commitment as Refusal

Already in 2012, it struck me that as they extended, “broad state conscience clauses, which safeguard a physician from performing any form of medical service contrary to conscience, might also be read to include willing providers.” The latest iteration of state bills makes all the more plausible that conscientious commitment could shade into legally protected refusal.

Nadia Sawicki’s contribution to this conference provides one example. For some time, state laws have required mandatory ultrasound and scripts that take positions on theological questions—abortion will “terminate the life of a whole, separate, unique, living human being—or require lies—abortion causes breast cancer or suicide. Faced, for example, with vulnerable patients, a provider might, in the exercise of conscience, say, “I cannot be forced to do what my conscience prohibits.” This claim looks identical to classic refusals. It falls squarely within the terms of the new anti-standard-of-care bills which define “healthcare service” to include but not be limited to “counseling,” “diagnosis or prognosis,” “recordkeeping or recordmaking,”

79. Sepper, Taking Conscience Seriously, supra note 4, at 1513.
and “instruction”—as well as a catch-all provision for “other care or services.”

Within states with such protections, this provider should be exempt from civil, criminal, or administrative liability.

Near-total abortion bans could prompt a number of scenarios where conscientious commitment tracks closely to the requirements of refusal laws. To take one example, numerous hospitals in states with abortion bans now mandate that physicians discharge patients who have pregnancy complications that previously would have permitted a D&C. Under new bill language, the provider could say “I refuse” and face no consequence.

Entire institutions could refuse to go along with an anti-abortion law. Consider, for example, a Montana measure defeated in a 2022 referendum. It would have required physicians to “take all medically appropriate and reasonable actions to preserve the life and health of” any infant born breathing or with a beating heart—no matter how premature or unlikely to live. As one specialist explained, instead of comfort care, he would have to do chest compressions or intubation, prolonging suffering at no medical benefit and depriving families of “being able to have some peaceful moments with their child.” Under the expansive version of refusal laws, an individual provider or entire institution could decline to engage in aggressive care, and civil and criminal sanctions could not apply.

Even under older refusal laws, some conscientious commitment may be legally protected as refusal. For example, under state abortion bans that exempt treatment of ectopic pregnancies, some hospitals are now prohibiting methotrexate, the standard of care for ectopic pregnancy, in favor of a salpingectomy, a surgical removal of portion of fallopian tube. This stance seems another instance of risk avoidance not required by law but set by institutional policy. Methotrexate, these hospitals seem to think, screams pregnancy termination. Faced with a patient with an ectopic pregnancy, a provider could refuse to participate as instructed. And even older conscience bills that allow refusal of abortion would seem to shield him from adverse employment action. This refusal takes the form of “I don’t want to do a salpingectomy,” no different from the provider whose refusal takes the form of “I don’t want to administer methotrexate.”

In areas beyond abortion, the new refusal laws create opportunities for conscientious providers to resist institutional policies. Providers might

80. Ark. Code Ann. § 17-80-503(5) (West 2022). “Participate” is defined equally broadly to mean “to provide, perform, assist with, facilitate, refer for, counsel for, advise with regard to, admit for the purposes of providing, or take part in any way in providing any healthcare service or any form of healthcare service.” Id. at § 17-80-503(7).

resist misgendering patients or prescribing transgender children antidepressants rather than puberty blockers. They might refuse to perform a c-section without offering tubal ligation. These claims would continue to have traction against institutions that don’t meet the definition of religious institution. (The carveout for religious institutions, in fact, could be understood as implicitly recognizing that conscience can favor provision and seeking to shield hospitals from these claims).

Through enforcement of the Church Amendment, the federal government also could spur greater recognition that abortion providers now face a crisis of conscience. This federal conscience law shields only those personnel who perform or assist in “lawful” abortions. Arguably, then, it would offer some protection for providers who live under abortion bans but travel to other states to perform abortions (or perhaps do telehealth abortions for patients in other states). The statute contains no private right of action, but the federal government could enforce it against states that discriminate—that is, threaten penalties—against willing providers.

I don’t want to exaggerate the potential for conscience laws to affect access to reproductive healthcare. Even the most expansive bills will not authorize regular abortion provision. The terms of existing abortion-related statutes nonetheless may provide some opportunity for resistance. By invoking a right to conscientious refusal, physicians in hospital settings may be able to gum up operations and create pressure on administrators to refrain from overreading and overenforcing already stringent abortion laws. Broader refusal statutes offer even more in the way of mechanisms for protest and change. For example, to generate more transgender-friendly institutional policies, providers could refuse to perform hysterectomies for any patient unless allowed to do them for patients with gender dysphoria diagnoses. They could refuse to discharge miscarriage patients, putting pressure on the hospital bottom line.

B. Destabilizing Institutional Categories

Institutional categories within refusal laws have always reflected some instability. The “most refusing refuser” phenomenon meant an entity’s mission and norms only sometimes prevailed. The same hospital could be refusing and protected in some circumstances, and willing and unprotected in others. New abortion bans and expansive anti-standard-of-care bills, however, present the possibility that institutional categories may bleed into one another and perhaps collapse.
First, the broadest of conscience laws may cover willing institutions, as the previous section suggested. As states limit in vitro fertilization, mandate reporting of parents providing gender-affirming care, or demand multiple physicians sign off on an exception from an abortion ban, willing institutions plausibly could refuse to comply in states with expansive refusal laws. In particular, religious institutions could use their religious status to shield some medical practice from state regulation and objecting dissenters.

This new generation of refusal laws presents an opportunity for willing religious institutions to free themselves from the employment provisions of state (though not federal) refusal laws. Standard bill language allows an institution that holds itself “out to the public as religious, states in its governing documents that it has a religious purpose or mission, and has internal operating policies or procedures that implement its religious beliefs” to make employment or staffing decisions, notwithstanding refusal laws that would otherwise demand absolute accommodation of refusers. Jewish, Methodist, and Episcopal hospitals could take advantage of this carveout. A religious identity would allow an institution to insist all staff deliver LGBTQ-affirming care, offer contraceptives, and respect patients’ reproductive decisions. These laws also might provide impetus for other institutions to declare their religious identity.

I want to raise a second point that may seem counterintuitive. Historical beneficiaries of refusal laws may find their own institutional norms and policies threatened by state bans on abortions (and perhaps other care). This contradiction arises from the fact that most institutions that refuse some reproductive services are willing to provide others. For example, Baptist hospitals routinely restrict some, but not all abortions. Faced with a patient who risks serious jeopardy to her health from continuing a pregnancy, a Baptist hospital’s policies could require an abortion to save her health. But the state ban may bar the procedure.

Take ectopic pregnancies. Idaho's abortion ban applies to all pregnancy termination, including ectopic pregnancy. Ectopic pregnancies can result in rupture of the tube, hemorrhage, and even death (the death rate is approximately...
nine to thirteen percent in developed countries). A hospital that ends a patient’s ectopic pregnancy could face criminal charges. It then would bear the burden of proving at trial that “the abortion was necessary to prevent the death of the pregnant woman.”

Catholic hospitals have religiously informed teachings that could lead them to violate Idaho’s law. According to Catholic ethical and religious directives, “In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.” But clinicians can, Catholic theologians agree, perform a salpingectomy, removing the fallopian tube for the primary purpose of preventing harm to the patient which has the secondary, but obvious effect of embryo’s demise. As a matter of religious doctrine, Catholic theologians and administrators might disavow that this procedure is an abortion. But, regardless, a salpingectomy falls within Idaho’s definition of abortion as it “intentionally terminate[s] the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child.”

Perhaps one is not convinced that refusing hospitals will feel conflict between religious teaching and current abortion bans. But other abortion-related laws will present trickier moral questions for healthcare institutions. New bills may call for mandatory reporting of pregnancy complications, miscarriages, or pregnancies—perhaps with threat of criminal prosecution of and long prison terms for people who are suspected of self-managing abortion. Already in Louisiana, physicians have expressed concern that Louisiana law may require them to report if they treat anyone for an abortion complication—in violation of patient privacy.

87. *IDAHO CODE* § 18-622(3)(a)(ii) and (iii).
89. Hamel, *supra* note 86.
90. *IDAHO CODE ANN.* § 18-604 (1) (West 2022)
91. Affidavit of Dr. Jennifer L. Avegno, Director of New Orleans Health Dep’t, *Plaintiffs’ Submission of Evidence of Motion for Preliminary Injunction*, June Med. Servs., LLC v. Landry, 2022-01589 (La. 12/20/22); 352 So. 3d 87, 143-144 (NO. C-720988), https://reproductiverights.org/wp-content/uploads/2022/07/2022-07-15_PLAINTIFFS-SUBMISSION-OF-EVIDENCE-C-720988.pdf [https://perma.cc/KC6U-VMYX] (“Physicians at one local hospital system have been told that there is no reporting requirement for treating complications of a suspected self-managed abortions—yet physicians at another local hospital system have been told that they do need to fill out the form in that scenario.”).
And so, red state policies will tend to destabilize the status of willing and refusing individuals and institutions. Where they are enacted, the next generation of refusal laws could prompt resistance from physicians and facilities dedicated to reproductive or LGBTQ-friendly care. They may spur greater embrace of religious institutional status by both refusing and willing hospitals, clinics, and physician offices. The next Part considers the state of conscience in jurisdictions committed to reproductive health services.

V. CONSCIENCE IN BLUE

As it became clear that the Supreme Court would gut the abortion right, legislatures in blue states moved to protect reproductive health. They expanded funding, licensed non-physicians to deliver abortion, and built safeguards against criminal, civil, or licensing enforcement against abortion providers.\(^{92}\) They aimed to provide an oasis for people seeking abortion at the edge of the abortion deserts that stretch across the South and Midwest.

At least initially, however, there may be less divergence between states than we expect, due in part to the laws authorizing and endorsing refusal. As Part A demonstrates, refusal is commonplace in many locales where abortion remains legal. In particular, the existing share of religious institutions functions as a choke point on reproductive services from contraception to sterilization to abortion. Part B considers the paths that abortion-friendly states can take to increase the supply of abortion care and identifies the obstacles that refusing objectors and conscience laws may cast in their way.

A. The Tentacular Reach of Refusal

The new state champions of abortion access had for too long been content to allow abortion services to be marginalized, unsupported, and stigmatized—despite fewer legal restraints as compared to other states. Because of their failure to mainstream abortion care, many of these states face a critical shortage of abortion providers.\(^{93}\) In Oregon, for example, by 2017, close to 80\% of counties did not have abortion facilities, and providers were geographically clustered, making access difficult for a quarter of


\(^{93}\) Garnet Henderson, *There’s an Abortion Provider Shortage Across the U.S. Here’s How We Address It*, ELLE (Nov. 18, 2021), https://www.elle.com/culture/career-politics/a38257180/abortion-provider-shortage-how-to-fix/ [https://perma.cc/MK2W-G84N].
Oregonians. Even in California, forty percent of counties—often large and rural counties—have no provider willing to deliver abortions. Accessing abortion can involve long journeys.

Virtually all states have conscience laws permitting refusal of abortion (and often sterilization). They also are bound by federal laws that prohibit them from discriminating against those institutions and individuals who deny abortion or sterilization. A few abortion-friendly states have statutes that have long stood out for their wide-ranging scope. Illinois, for example, a state essential to abortion access for residents of surrounding states, authorizes refusal to participate in “any particular form of health care service which is contrary to” conscience. Washington too permits denial of any “service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.”

Under these laws, access is squeezed from two sides. First, willing institutions and individuals are held hostage by refusing staff. According to a survey of hospital-affiliated ob-gyns, 91 percent reported that they or their colleagues had wanted or needed to provide abortions in the prior year. But a full 59 percent had had to deny care due to resistance to participation from colleagues, most commonly nurses, nursing administration, or anesthesiologists. One ob-gyn director in the Northeast explained that patients there had to leave the city altogether for abortion care, not because the providers or equipment was unavailable, but because “some of our staff are uncomfortable.”

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96. Sawicki, supra note 18, at 1285–86 (noting that the exceptions are Colorado, Vermont, and New Hampshire).

97. 745 ILL. COMP. STAT. 70/4 (2019); id. § 70/3(a).

98. WASH. REV. CODE §§ 70.47.160(2)(a); id. § 48.43.005(25).

99. Ariana H. Bennett et al., Interprofessional Abortion Opposition: A National Survey and Qualitative Interviews with Abortion Training Program Directors at U.S. Teaching Hospitals, 52 PERSPECTIVES ON SEXUAL & REPRO. HEALTH 235 (2020).

100. Varvara Zeldovich, Abortion Policies in U.S. Teaching Hospitals: Formal and Informal Parameters Beyond the Law, 135 OBSTETRICS & GYNECOLOGY 1296 (2020); see also Platt et al, supra note 58, at 31–32 (describing doctors’ reports that lack of anesthesiologists or medical assistants meant they were often or totally unable to provide services).
Second and simultaneously, hospitals with policies of denying reproductive care—motivated by religion or otherwise—impede and delay emergency provision and bind willing providers in their facilities. Within a decade after Roe, the vast majority of hospitals came to disfavor provision of abortion out of fear of reputational damage. And from 1982 to 2017, the number of hospitals providing abortions further declined from 1405 to 518. Even under permissive abortion laws, many hospitals permit only “therapeutic” abortions—a term more moral than medical and thus exclude situations that lay people would view as urgent or emergent. Refusal is often surreptitious. Most patients are unaware of the possibility of refusal, let alone able to identify where and when a hospital might deny care. And so, even as the medical dilemmas provoked by abortion bans gain attention, “many of these outrages exist in states where abortion is perfectly legal—because of the policies of hospitals.”

In particular, Catholic hospitals with restrictions on reproductive care dominate many markets in abortion-friendly states, particularly in the Northwest and Midwest. Over the last two decades, the number of Catholic hospitals has shown a substantial 28% growth, even as the rest of the market has shrunk almost 14%. Hospitals with Catholic affiliation control more than 1 out of 7 beds nationwide but hold considerably larger market shares in many communities. In Alaska, Iowa, Washington, and Wisconsin,

103. Platt et al., supra note 58, at 9.
104. Ramesh Raghavan, A Question of Faith, 297 JAMA 1412 (2007) (describing his wife’s miscarriage of twins at 21 weeks pregnancy with fetal membranes bulging into the vaginal canal and one twin no-longer viable where the D&C of the other fetus was not considered therapeutic).
105. Deborah B. Stulberg et al., Women’s Expectation of Receiving Reproductive Health Care at Catholic and Non-Catholic Hospitals, 51 PERSPECTIVES ON SEXUAL & REPRO. HEALTH 135 (2019).
40 percent or more of hospital beds are in Catholic facilities. In Illinois, one-third of birthing hospitals are Catholic. And the situation seems unlikely to improve in the short term for three reasons. First, healthcare systems—including those with limitations on healthcare—are rapidly rolling up physician practices. Over the last decade, hospital systems increasingly have employed physicians. The shift from physician-owned to hospital-owned practices and from independent contractor to employee status grants institutional actors more control. Religious restrictions stretch further than they once did, beyond hospital corridors to physician offices and ambulatory surgery centers. For example, after Ascension purchased the only hospital in Bartlesville, Oklahoma, every ob-gyn in the city but one risked losing their ability to prescribe contraceptives for birth control purposes—access that was only preserved due to public backlash. Note too that the federal conscience law, the Church Amendment, which bans discrimination against physicians who provide abortion outside of the hospital, would not seem to extend to in-office abortions in buildings that the hospital owns.

And it’s not only refusing institutions that are exercising control over staff. In states with liberal abortion laws, major medical centers have advised providers not to advertise abortion care and have barred them

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110. Wong et al., supra note 63, at 63.
111. Joanne Finnegan, Report: 8,000 medical practices acquired by hospitals in 18 months, FIERCE HEALTHCARE (Feb. 21, 2019), https://www.fiercehealthcare.com/practices/consolidation-trend-continues-8-000-more-hospital-owned-practices-14-000-more-hospital (noting “some 44% of physicians were employed by hospitals or health systems as of January 2018, compared to just 1 in 4 in 2012”).
from speaking about the plight of patients fleeing states with bans.\textsuperscript{114} As one physician in the Northeast said, “They’re censoring me. It’s shameful and embarrassing to work for an institution that is not supportive of women’s rights.”\textsuperscript{115} Medical staff find themselves muzzled even in states and hospitals willing to offer comprehensive reproductive care.

Second, horizontal partnerships link refusing and non-refusing institutions in ways that may lead all entities (and their staff) to be subject to religious doctrine. As I have documented elsewhere, through contract, religious healthcare institutions have negotiated for religious compliance as part of hospital sales, joint ventures, operating agreements, and management contracts.\textsuperscript{116} As a result, hospitals that are secular, affiliated with pro-choice religions, or even public abide by restrictions on reproductive healthcare.\textsuperscript{117} There are a number of zombie religious institutions—hospitals sold by a religious healthcare system to a secular buyer—that continue to refuse care or assert a religious identity. One large empirical study found that when Catholic hospitals were sold to a non-Catholic buyer, the numbers of tubal ligations billed to insurance did not rise—indicating that the religious policies continued although the owner was no longer religious.\textsuperscript{118} By contrast, when a Catholic system purchased hospitals, their rates of tubal ligations plummeted.\textsuperscript{119}

Third and relatedly, the U.S. Conference of Catholic Bishops has become more stringent in its interpretation of Catholic doctrine. The most recent version of the ERDs demands compliance with Catholic restrictions by any affiliate, however loosely connected. Whereas Catholic healthcare once entered into collaborations that allowed the secular partner to maintain its identity, the 2018 directives require that all entities “be operated in full accord with the moral teaching of the Catholic Church” regardless of whether the collaboration comes in the form of “acquisition, governance, or management.”\textsuperscript{120} A new directive specifies that in collaborations, no

\begin{itemize}
\item \textsuperscript{117} \textit{Id.} at 940–47; see also Elizabeth Sepper & James D. Nelson, \textit{Government’s Religious Hospitals}, 109 VA. L. Rev. 61 (2023) (uncovering and analyzing mergers of government and religious entities in hospitals).
\item \textsuperscript{118} Elaine L. Hill et al., \textit{Reproductive Health Care in Catholic-Owned Hospitals}, 65 J. of Health Econ. 48 (2019).
\item \textsuperscript{119} \textit{Id.} at 60.
\item \textsuperscript{120} \textit{Catholic Bishops, Ethical and Religious Directives, supra note 75, at 74.}
\end{itemize}
administrator or employee of Catholic healthcare can make referrals for or “benefit from the revenue generated by immoral procedures.” Compromises that used to preserve or ensure care have been ruled out. Refusal is thus commonplace in and across states favorable to abortion care. Catholic hospital systems hold economic power in concentrated markets. Willing providers work under systems of restraint or find their attempts to deliver care delayed or denied by refusing colleagues. Entire markets have no provider able to offer accessible reproductive healthcare. This reality makes realizing abortion safe havens a daunting task.

B. State Responses and Legal Obstacles

This Section considers a few options to alleviate access and conscience issues arising from market-wide refusal. It also identifies various obstacles to those solutions.

The most straightforward way to address inadequate provision would be direct regulation. A state might legislate, for example, that all hospitals with the capacity for labor and delivery also offer abortions. A narrower option would specify emergency obligations on hospitals to deliver abortion care—making more precise or expanding beyond the duties of the federal EMTALA. Such reforms, however, would be fiercely resisted by powerful healthcare systems and, if enacted, likely would prompt lawsuits. I suspect states instead will start with measures that are either more incremental or less subject to constitutional litigation. The first category would spur market mechanisms. Lori Freedman and Alta Charo, for example, make a “modest proposal” that institutions disclose policies of refusal and allow individual providers to provide information and referrals consistent with their own moral convictions. On this view, patients armed with information could find services in the healthcare market. Washington State already has adopted this approach. A second category

121. Id. at 73.
124. WASH. REV. CODE ANN. § 70.03.020 (West 2022) (prohibiting healthcare entities from limiting providers from providing accurate and comprehensive information to patients
of reforms would harness the state’s role in ensuring market competition and availability of community healthcare. For example, some states have begun to consider the effect of mergers and other transactions on reproductive and LGBTQ-affirming services and to condition their approval on the maintenance of such care.\textsuperscript{125}

The narrowing of refusal legislation also seems in order. Washington and Illinois have long been outliers, permitting refusal under a range of circumstances so wide as to invite discrimination, burden other providers, and harm patients. Their legislatures should narrow the reach of their statutes. Other states should move to rescind the immunity provisions of their refusal laws. While the non-discrimination elements of conscience laws can serve to foster pluralism and a live-and-let live system, immunity for inflicting injury on patients creates bad incentives and can literally strip patients of their right to life. Patients injured by refusal should have remedies for harm.

Abortion-friendly states also should enact safeguards for conscientious commitment. Washington, for example, now prohibits hospitals from restricting medical professionals’ treatment of patients with pregnancy complications. Prompted by a Washington woman’s near death after being denied treatment for a miscarriage by a Catholic hospital, the legislature enacted the Protecting Pregnant Patients Act. It prevents healthcare entities from disciplining, firing, or otherwise discriminating against any healthcare provider who disobeys a restriction that violates the standard of care, risks a patient’s life, or results in irreversible harm to a patient experiencing pregnancy complication.\textsuperscript{126} In effect, this act authorizes provision as other laws permit refusal. Future reforms might take up the language of conscience and present such bills as “Protection of Conscience” acts. In so doing, they could potentially change the dialogue and move from a one-sided to a multi-faceted view of conscience.

States may need to consider cordoning off spaces of institutional refusal more generally. With liberalized laws and state funding, a larger number of providers might choose to dispense medication abortion, which requires no specialized skill. But some, perhaps substantial, percentage of providers will be prevented from doing so under their contracts with hospital systems. Under such circumstances, states might legislate to preserve a measure of independence for providers outside the hospital corridors and in their

\textsuperscript{125} Sepper & Nelson, supra note 117, at 110–17.

about the patient’s health status, treatment options, and referral); WASH. REV. CODE ANN. § 70.41.520 (West 2020) (requiring posted disclosure).
offices. At minimum, states will need to closely monitor the impact of vertical integration on access.

These reforms are not without their difficulties. The Supreme Court’s interpretation of the First Amendment hems in reproductive healthcare policymaking. Casting a shadow over efforts toward transparency, *NIFLA v. Becerra* struck down a law requiring crisis pregnancy centers to disclose their staffing and services as a violation of the Free Speech Clause.\(^\text{127}\) Recent interpretations of religion law doctrine also bode ill for the regulation of religious healthcare institutions. In particular, the Court has come to embrace increasingly attenuated claims of complicity.\(^\text{128}\)

Where states seek to expand access, institutions will likely mount constitutional claims. With the aid of Christian nationalist litigation shops, religious medical associations and hospital conglomerates are already fighting sex antidiscrimination laws, disclosure and record-keeping requirements for medical aid-in-dying, and duties of emergency care for pregnancy complications.\(^\text{129}\) In cases around the country, religious claimants have been pushing the boundaries of when remote participation in the activities of others implicates religious conscience.\(^\text{130}\) If a business becomes complicit in the sexual and reproductive decisions of its employees by offering insurance, then it is hard to see how staff could provide care in a way that wouldn’t implicate the purported religious conscience of the hospital.

Some strategies could sidestep constitutional challenges. For example, state efforts targeting mergers that reduce care—and consumer welfare—

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128. Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014) (including contraceptive coverage in employee insurance plans substantially burdened the employer’s religious exercise); Little Sisters of the Poor v. Pa., 140 S. Ct. 2367, 2391 (2020) (Alito, J., concurring) (taking the view that requiring a religious employer to even certify their eligibility for exemption constitutes a substantial burden).

129. Christian Med. v. Bonta, 2022 U.S. Dist. LEXIS 235307 (C.D. Cal. 2022) (raising free speech, free exercise, due process, and equal protection against California law requiring that physicians (1) inform patients if they do not participate in medical aid in dying, (2) chart patient’s request, and (3) transfer patient’s medical record upon request); Texas v. Becerra, 2022 U.S. Dist. LEXIS 234341 (N.D. Tex. 2022) (The Christian Medical and Dental Association joining cause with the state of Texas to argue that any obligation to provide stabilizing abortion care under EMTALA cannot be enforced against religious objectors).

are relatively safe from attack under the First Amendment. This kind of plain vanilla pro-competitive enforcement of health and competition regulations will be more difficult to resist. Another tactic might be to limit requirements to deliver abortion to secular and public hospitals, while exempting religiously affiliated hospitals. A lower-hanging fruit would be to mandate abortion at public hospitals that provide maternity benefits, as Washington state has long done, or at public health clinics, as New Mexico recently ordered. Other public entities could also be harnessed, as Massachusetts has begun to do with universities. Public institutions could likewise provide space and support to willing providers who work under rules against abortion care.

Across many of these efforts, there is a looming risk of expansive interpretation of federal conscience laws under future Republican administrations. The Trump Administration, for example, prioritized refusal. It created the new Conscience and Religious Freedom Division in HHS and issued an expansive rule entitled “Protecting Statutory Conscience Rights In Health Care.” After California mandated abortion coverage within employer-sponsored insurance plans, the Department of Justice and HHS argued that the state had violated the Weldon Amendment and it thus disallowed $200 million per quarter from California’s Medicaid program. Congressional Republicans continue to introduce expanded legislation which would shield insurance plans, create private rights of action, and allow refusal of abortions in emergencies.

In sum, to ensure access in a market choked by refusal policies, states supportive of abortion will need to legislate carefully and creatively. Resistance through the courts and perhaps from the federal government should be expected.

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VI. CONCLUSION

Conscience will be central to the configuration of our post-"Roe" landscape. In states with abortion bans, we will continue to see willing individuals, like Dr. S, have to sacrifice their consciences. Now, however, they also will confront serious criminal penalties should they determine to act. Refusing individuals meanwhile will be further emboldened to act according to conscience (or for other reasons) in the teeth of ethical obligation and employer interests.

Institutions will remain important to creating and resolving crises of conscience. Abortion bans tend to make hospitals the epicenter of exceptions. Pregnant patients seek them out in urgent and emergent situations. Hospitals’ interpretation of restrictions and exceptions will further bind or free providers of conscience. Surveillance and control will characterize medical practice.

States that attempt to create abortion safe havens will find that institutional actors pose major barriers to healthcare access and individual exercise of conscience. In many jurisdictions, refusing healthcare systems dominate. Religious restrictions have seeped into unlikely settings like secular hospitals and leased office spaces. Possible reforms could harness competition policy, mandate transparency, or require care. Framed correctly, state efforts could acknowledge the equal conscience of providers and transform discussions of reproductive care.

Ultimately, as the chasm in legal treatment of conscientious refusal and provision yawns wider in abortion-restrictive states, it reveals legislative concerns about conscience to be a mere façade. Expansive statutory language in recent bills will prompt complex questions about what it means to “refuse” care and about the relationship of conscientious providers and institutions to each other.